

		FOR OHF USE					

LL 1

**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038331</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Heritage Manor-Streator</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>1525 E. MAIN STREET</u> <u>Streator</u> <u>61701</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>LaSalle</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>( 815 ) 672-4516</u> <b>Fax #</b> ( ) _____		(Type or Print Name) <u>CRAIG L. ATER</u>	
<b>IDPA ID Number:</b> <u>370909086014</u>		(Title) <u>Senior Vice President -- Finance</u>	
<b>Date of Initial License for Current Owners:</b> <u>1964</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) _____	
<input type="checkbox"/> Charitable Corp.		(Telephone) <u>( 309 ) 823-7135</u> <b>Fax #</b> ( ) _____	
<input type="checkbox"/> Trust		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b>	
<b>IRS Exemption Code</b> _____		<b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>	
<input checked="" type="checkbox"/> PROPRIETARY		<b>201 S. Grand Avenue East</b>	
<input type="checkbox"/> Individual		<b>Springfield, IL 62763-0001</b>	
<input type="checkbox"/> Partnership		<b>Phone # (217) 782-1630</b>	
<input type="checkbox"/> Corporation			
<input checked="" type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>GOVERNMENTAL</b>			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>CRAIG L. ATER</u> <b>Telephone Number:</b> <u>( )</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Heritage Manor-Streator# 0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>110</u>	Skilled (SNF)	<u>110</u>	<u>40,150</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4		Intermediate/DD			4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6		ICF/DD 16 or Less			6
7	<u>110</u>	TOTALS	<u>110</u>	<u>40,150</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>26,395</u>	<u>9,837</u>	<u>2,208</u>	<u>38,440</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS					13
14	TOTALS	<u>26,395</u>	<u>9,837</u>	<u>2,208</u>	<u>38,440</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 95.74%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1964

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date 1964 NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided 2,208

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: \_\_\_\_\_ Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Heritage Manor-Streator

# 0038331

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	238,182	22,593		260,775		260,775	3,769	264,544		1
2	Food Purchase		169,806		169,806		169,806	(857)	168,949		2
3	Housekeeping	95,523	24,155		119,678		119,678		119,678		3
4	Laundry	45,672	16,869		62,541		62,541		62,541		4
5	Heat and Other Utilities			65,086	65,086		65,086	1,173	66,259		5
6	Maintenance	73,338	24,984	20,218	118,540		118,540	10,142	128,682		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	452,715	258,407	85,304	796,426		796,426	14,227	810,653		8
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	1,382,304	122,812	5,536	1,510,652		1,510,652		1,510,652		10
10a	Therapy		236,268	43,336	279,604	(391,337)	(111,733)	183,050	71,317		10a
11	Activities	71,091	2,709		73,800		73,800		73,800		11
12	Social Services	21,670	103	4,655	26,428		26,428		26,428		12
13	Nurse Aide Training	7,965	582		8,547		8,547	2,095	10,642		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,483,030	362,474	53,527	1,899,031	(391,337)	1,507,694	185,145	1,692,839		16
	<b>C. General Administration</b>										
17	Administrative	67,969			67,969		67,969	97,405	165,374		17
18	Directors Fees							5,170	5,170		18
19	Professional Services			264,252	264,252		264,252	(254,519)	9,733		19
20	Dues, Fees, Subscriptions & Promotions			76,474	76,474	(60,225)	16,249	(2,370)	13,879		20
21	Clerical & General Office Expenses	132,061	7,776	17,231	157,068		157,068	204,881	361,949		21
22	Employee Benefits & Payroll Taxes			353,338	353,338		353,338	26,791	380,129		22
23	Inservice Training & Education			1,158	1,158		1,158	841	1,999		23
24	Travel and Seminar			7,435	7,435		7,435	(5,436)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			41,555	41,555		41,555	1,973	43,528		26
27	Other (specify):*			7,720	7,720		7,720	(7,651)	69		27
28	<b>TOTAL General Administration</b>	200,030	7,776	769,163	976,969	(60,225)	916,744	67,085	983,829		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,135,775	628,657	907,994	3,672,426	(451,562)	3,220,864	266,457	3,487,321		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Heritage Manor-Streator

#0038331

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			99,479	99,479		99,479	12,877	112,356			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,996	65,996		65,996	141	66,137			32
33	Real Estate Taxes			46,195	46,195		46,195		46,195			33
34	Rent-Facility & Grounds							7,392	7,392			34
35	Rent-Equipment & Vehicles			7,407	7,407		7,407	11,408	18,815			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			219,077	219,077		219,077	31,818	250,895			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					391,337	391,337		391,337			39
40	Barber and Beauty Shops		624	6,840	7,464		7,464		7,464			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					60,225	60,225		60,225			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		624	6,840	7,464	451,562	459,026		459,026			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,135,775	629,281	1,133,911	3,898,967		3,898,967	298,275	4,197,242			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Heritage Manor-Streator

# 0038331

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,213)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,252	30		9
10	Interest and Other Investment Income	(100)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(857)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(567)	20		17
18	Fines and Penalties				18
19	Entertainment	(11,983)	24		19
20	Contributions	(1,651)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(23)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	27		24
25	Fund Raising, Advertising and Promotional	(5,812)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (26,954)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	325,229		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 325,229		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ 298,275		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Streator

ID# 0038331

Report Period Beginning: 1/01/2002

Ending: 12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$	0	0
2		0	0
3		0	0
4		0	0
5		(3,213)	35
6		0	34
7		0	
8		0	
9		3,252	30
10			32
11		0	
12		0	
13		(857)	2
14		0	32
15		0	33
16		0	24
17		(567)	20
18		0	
19			24
20		(1,651)	27
21		0	
22		(23)	19
23		0	
24		(6,000)	27
25		(5,812)	20
26		0	0
27		0	0
28		0	0
29		0	0
30		0	0
31		0	0
32			
33		0	33
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49	Total	(14,871)	

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heritage Manor-Streator

# 0038331

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	3,769	0	0	0	0	0	0	0	0	3,769	1
2	Food Purchase	(857)	0	0	0	0	0	0	0	0	0	0	(857)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,173	0	0	0	0	0	0	0	0	1,173	5
6	Maintenance	0	0	10,142	0	0	0	0	0	0	0	0	10,142	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(857)</b>	<b>0</b>	<b>15,084</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>14,227</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	183,050	0	0	0	0	0	0	0	0	0	183,050	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	2,095	0	0	0	0	0	0	0	0	2,095	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>183,050</b>	<b>2,095</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>185,145</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	97,405	0	0	0	0	0	0	0	0	97,405	17
18	Directors Fees	0	0	5,170	0	0	0	0	0	0	0	0	5,170	18
19	Professional Services	(23)	(264,229)	9,733	0	0	0	0	0	0	0	0	(254,519)	19
20	Fees, Subscriptions & Promotions	(6,379)	0	4,009	0	0	0	0	0	0	0	0	(2,370)	20
21	Clerical & General Office Expenses	0	0	204,881	0	0	0	0	0	0	0	0	204,881	21
22	Employee Benefits & Payroll Taxes	0	0	26,791	0	0	0	0	0	0	0	0	26,791	22
23	Inservice Training & Education	0	0	841	0	0	0	0	0	0	0	0	841	23
24	Travel and Seminar	(11,983)	0	6,547	0	0	0	0	0	0	0	0	(5,436)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,973	0	0	0	0	0	0	0	0	1,973	26
27	Other (specify):*	(7,651)	0	0	0	0	0	0	0	0	0	0	(7,651)	27
28	<b>TOTAL General Administration</b>	<b>(26,036)</b>	<b>(264,229)</b>	<b>357,350</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>67,085</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(26,893)</b>	<b>(81,179)</b>	<b>374,529</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>266,457</b>	<b>29</b>

## Summary B

12/31/2002

## 12/31/2002

[illegible]



Facility Name & ID Number Heritage Manor-Streator# 0038331

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organization	58,436	GreenTree Therapy	100.00%	49,407	(9,029)	2
3	V								3
4	V	19	Adjustment for Related Organization	264,229	Heritage Enterprises, Inc.	100.00%		(264,229)	4
5	V								5
6	V	10a	Adjustment for Related Organization	203,537	GreenTree Pharmacy	100.00%	395,616	192,079	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 526,202			\$ 445,023	\$ * (81,179)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Streator# 0038331Report Period Beginning: 1/01/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 3,769	\$ 3,769
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				1,173	1,173
20	V	6 Maintenance				10,142	10,142
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				2,095	2,095
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				97,405	97,405
30	V	18 Directors Fees				5,170	5,170
31	V	19 Professional Services				9,733	9,733
32	V	20 Fees, Subscription, Promotions				4,009	4,009
33	V	21 Clerical & General Office Expenses				204,881	204,881
34	V	22 Employee Benefits & Payroll Taxes				26,791	26,791
35	V	23 Inservice Training & Education				841	841
36	V	24 Travel and Seminar				6,547	6,547
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,973	1,973
39	Total		\$			\$ 374,529	\$ * 374,529

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Streator# 0038331Report Period Beginning: 1/01/2002Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V	30 Depreciation				9,625	9,625
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				241	241
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				7,392	7,392
21	V	35 Rent-Equipment & Vehicles				14,621	14,621
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 31,879	\$ * 31,879

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Heritage Manor-Streator # 0038331 Report Period Beginning: 1/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	26.00	397,396	5	100.00	Director/Salary	\$ 18,205	line 17/18, col	1
2	Tom Jefferson	Asst Secretary/Treas	Management	10.00	390,860	5	100.00	Director/Salary	17,907	line 17/18, col	2
3	Craig Hart	Secretary/Treasurer	Management	20.00	343,058	10	100.00	Director/Salary	15,717	line 17/18, col	3
4	Joe Warner	President	Management	2.50	370,366	40	100.00	Director/Salary	16,968	line 17/18, col	4
5	Bob Dickson	Executive Vice Presid	Management	0.80	92,266	40	100.00	Salary	4,227	line 17, col 7	5
6	Cheryl Lowney	Executive Vice Presid	Management	0.30	186,564	50	100.00	Director/Salary	8,547	line 17/18, col	6
7	Steve Wannemacher	Executive Vice Presid	Management	0.30	175,068	50	100.00	Director/Salary	8,021	line 17/18, col	7
8	Connie Hoselton	Sr Vice President	Management	0.17	140,191	40	100.00	Salary	6,423	line 17, col 7	8
9	Craig Ater	Sr Vice President	Management	0.21	143,176	50	100.00	Salary	6,560	line 17, col 7	9
10											10
11											11
12											12
13								TOTAL	\$ 102,575		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Streator# 0038331

Report Period Beginning:

1/01/2002Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,401	24	\$ 82,266	\$ 82,266	110	\$ 3,769	1
2	2 Food Purchase	Beds	2,401	24	0	0	110	0	2
3	3 Housekeeping	Beds	2,401	24	0	0	110	0	3
4	4 Laundry	Beds	2,401	24	0	0	110	0	4
5	5 Heat & Other Utilities	Beds	2,401	24	25,593	0	110	1,173	5
6	6 Maintenance	Beds	2,401	24	221,381	58,785	110	10,142	6
7	7 Other	Beds	2,401	24	0	0	110	0	7
8	9 Medical Director	Beds	2,401	24	0	0	110	0	8
9	10 Nursing & Medical Records	Beds	2,401	24	0	0	110	0	9
10	11 Activities	Beds	2,401	24	0	0	110	0	10
11	12 Social Service	Beds	2,401	24	0	0	110	0	11
12	13 Nurse Aide Training	Beds	2,401	24	45,737	39,267	110	2,095	12
13	14 Program Transportation	Beds	2,401	24	0	0	110	0	13
14	15 Other	Beds	2,401	24	0	0	110	0	14
15	17 Administrative	Beds	2,401	24	2,126,096	2,126,096	110	97,405	15
16	18 Directors Fees	Beds	2,401	24	112,849	0	110	5,170	16
17	19 Professional Services	Beds	2,401	24	212,454	0	110	9,733	17
18	20 Fees, Subscription, Promotions	Beds	2,401	24	87,500	0	110	4,009	18
19	21 Clerical & General Office Expense	Beds	2,401	24	4,472,002	4,183,145	110	204,881	19
20	22 Employee Benefits & Payroll Tax	Beds	2,401	24	584,769	0	110	26,791	20
21	23 Inservice Training & Education	Beds	2,401	24	18,362	0	110	841	21
22	24 Travel and Seminar	Beds	2,401	24	142,902	0	110	6,547	22
23	25 Other Admin. Staff Transportation	Beds	2,401	24	0	0	110	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,401	24	43,070	0	110	1,973	24
25	TOTALS				\$ 8,174,981	\$ 6,489,559		\$ 374,529	25

Facility Name & ID Number Heritage Manor-Streator# 0038331 Report Period Beginning: 1/01/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,401	24	\$	\$	110	\$	1
2	30 Depreciation	Beds	2,401	24	210,090		110	9,625	2
3	31 Amortization of Pre-Op & Org	Beds	2,401	24			110		3
4	32 Interest	Beds	2,401	24	5,270		110	241	4
5	33 Real Estate Taxes	Beds	2,401	24			110		5
6	34 Rent-Facility & Grounds	Beds	2,401	24	161,349		110	7,392	6
7	35 Rent-Equipment & Vehicles	Beds	2,401	24	319,142		110	14,621	7
8	36 Other	Beds	2,401	24			110		8
9	38 Medically Nec Transportation	Beds	2,401	24			110		9
10	39 Ancillary Service Centers	Beds	2,401	24			110		10
11	40 Barber and Beauty Shops	Beds	2,401	24			110		11
12	41 Coffee and Gift Shops	Beds	2,401	24			110		12
13	42 Other	Beds	2,401	24			110		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 695,851	\$		\$ 31,879	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$ 2,433,749	\$ 1,035,439	01/15/06	variable	\$ 42,282	1	
2	LSalle National Bank		xx	Mortgage							4,844	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Central Office Allocation		xx	Working Capital							18,870	6	
7	Central Office Allocation		xx	Working Capital							241	7	
8												8	
9	TOTAL Facility Related						\$ 2,433,749	\$ 1,035,439			\$ 66,237	9	
	B. Non-Facility Related*												
10	Interest Income										(100)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (100)	14	
15	TOTALS (line 9+line14)						\$ 2,433,749	\$ 1,035,439			\$ 66,137	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Heritage Manor-Streator COUNTY LaSalle

FACILITY IDPH LICENSE NUMBER 0038331

CONTACT PERSON REGARDING THIS REPORT Craig Ater

TELEPHONE ( 309 ) 823-7135 FAX #: (    )   

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>3431112000</u>	<u>Nursing Home</u>	\$ <u>44,111.00</u>	\$ <u>44,111.00</u>
2. <u>3431129000</u>	<u>Nursing Home</u>	\$ <u>1,737.00</u>	\$ <u>1,737.00</u>
3. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                   </u>	<u>                   </u>	\$ <u>                   </u>	\$ <u>                   </u>
<b>TOTALS</b>		\$ <u><u>45,848.00</u></u>	\$ <u><u>45,848.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 33,800

B. General Construction Type:
 Exterior
 Brick/Wood
 Frame
 Number of Stories

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

---



---



---



---



---



---



---

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 17,000	1
2					2
3	TOTALS			\$ 17,000	3

Facility Name &amp; ID Number Heritage Manor-Streator

# 0038331

Report Period Beginning:

1/01/2002

Ending:

12/31/2002

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	110			\$ 348,848	\$		\$	\$
5				440,122				
6								
7								
8								
<b>Improvement Type**</b>								
9	1980 Improvements	1980		12,172				
10	1981 Improvements	1981		13,748				
11	1982 Improvements	1982		18,366				
12	1983 Improvements	1983		9,250				
13	1984 Improvements	1984		1,329				
14	1985 Improvements	1985		4,100				
15	1986 Improvements	1986		57,336				
16	1987 Improvements	1987		6,225				
17	1988 Improvements	1988		48,818				
18	1989 Improvements	1989		22,687				
19	1990 Improvements	1990		31,584				
20	1991 Improvements	1991		3,560				
21	1992 Improvements	1992		19,172				
22	1993 Improvements	1993		23,135				
23	1994 Improvements	1994		22,036				
24	1995 Improvements	1995		39,228				
25	YORK CONDENSING UNIT	1996		3,910				
26								
27								
28								
29								
30								
31								
32								
33								
34	C/O Allocation						9,625	9,625
35	Book Depreciation				55,935		59,586	3,651
36								1,026,115

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Interior Rehab---Facility	1997	\$ 286,974	\$		\$	\$	\$		37
38	Roof	1997	5,232							38
39	Sprinkler System	1997	9,530							39
40	Code Alert	1997	1,879							40
41										41
42	Code Alert	1998	2,000							42
43	Bathroom Door	1998	656							43
44	Interior Rehab	1998	11,815							44
45										45
46	Door Alarms	1999	3,675							46
47										47
48	Water Heater	2000	4,114							48
49	Exhaust Fans	2000	931							49
50	Booster Heater -- Water Heater	2000	1,465							50
51										51
52	Professional Fees---Building Renovation	2001	27,964							52
53	Sprinkler Replacement	2001	4,955							53
54	AC Unit with Installation	2001	4,372							54
55	Exterior Painting	2001	6,545							55
56	Code Alert System	2001	4,592							56
57										57
58	Roof	2002	48,840							58
59	Sewer line	2002	20,615							59
60	Condensing Unit	2002	1,213							60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,572,993	\$ 55,935		\$ 69,211	\$ 13,276	\$ 1,026,115		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,572,993	\$ 55,935		\$ 69,211	\$ 13,276	\$ 1,026,115	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,572,993	\$ 55,935		\$ 69,211	\$ 13,276	\$ 1,026,115	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 663,816	\$ 43,544	\$ 43,145	\$ (399)		\$ 570,953	71
72	Current Year Purchases	29,488						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 693,304	\$ 43,544	\$ 43,145	\$ (399)		\$ 570,953	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,283,297	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 99,479	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,356	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,877	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,597,068	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 18,815 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ \_\_\_\_\_

13. /2004 \$ \_\_\_\_\_

14. /2005 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$		\$			
2	Books and Supplies		582		582		
3	Classroom Wages (a)		7,965		7,965		
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	8,547	\$	8,547		
10	SUM OF line 9, col. 1 and 2 (e)	\$	8,547				

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.



XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a/3	hrs	\$		
2	Licensed Speech and Language Development Therapist	10a/3	hrs			21,550				21,550	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a/3	hrs			(6,481)	39,536			33,055	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39/3	# of prescrpts				388,811			388,811	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify): x-ray	39/3				2,526				2,526	13
14	TOTAL			\$		\$ 34,307	\$ 428,347		\$	462,654	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Heritage Manor-Streator

# 0038331

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 18,103	\$	1
2	Cash-Patient Deposits	8,272		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	464,370		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,407		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,877,092		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,396,244	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	1,445,280		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	668,098		16
17	Accumulated Depreciation (book methods)	(1,047,721)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deferred Tax Asset</u>	14,936		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,130,593	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 6,526,837	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 78,207	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,272		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	240,596		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,695		31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,141		32
33	Accrued Interest Payable	3,046		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Security Deposits</u>	15,180		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 396,137	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,035,439		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,035,439	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,431,576	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 5,095,261	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 6,526,837	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 4,686,472</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Audit Adjustment</u>	<b>12,999</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 4,699,471</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>395,790</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 395,790</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 5,095,261</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 4,343,989	1
2	Discounts and Allowances for all Levels	(535,193)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,808,796	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	126,014	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 126,014	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	9,273	11
12	Gift and Coffee Shop	862	12
13	Barber and Beauty Care	10,944	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	350,010	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,444	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 372,533	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	100	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 100	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,307,443	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	796,426	31
32	Health Care	1,899,031	32
33	General Administration	976,969	33
<b>B. Capital Expense</b>			
34	Ownership	219,077	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,464	35
36	Provider Participation Fee		36
<b>D. Other Expenses (specify):</b>			
37	<u>Loss from Non-Nursing property</u>	12,686	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,911,653	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	395,790	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 395,790	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

Page 20

Facility Name &amp; ID Number Heritage Manor-Streator

# 0038331

Report Period Beginning: 1/01/2002

Ending:

12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,579	1,969	\$ 42,220	\$ 21.44	1
2	Assistant Director of Nursing	2,240	2,288	51,485	22.50	2
3	Registered Nurses	8,463	9,592	188,731	19.68	3
4	Licensed Practical Nurses	14,145	15,493	269,875	17.42	4
5	Nurse Aides & Orderlies	70,952	76,900	768,827	10.00	5
6	Nurse Aide Trainees	1,219	1,219	7,965	6.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,818	5,242	61,166	11.67	8
9	Activity Director					9
10	Activity Assistants	7,886	8,583	71,091	8.28	10
11	Social Service Workers	1,874	2,060	21,670	10.52	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,608	22,607	238,182	10.54	15
16	Dishwashers					16
17	Maintenance Workers	6,019	6,651	73,338	11.03	17
18	Housekeepers	11,375	12,379	95,523	7.72	18
19	Laundry	5,505	6,156	45,672	7.42	19
20	Administrator	2,080	2,080	67,969	32.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,603	9,747	132,061	13.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	173,366	182,966	\$ 2,135,775 *	\$ 11.67	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		0		36
37	Medical Records Consultant		300		37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,156		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		4,655		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 8,111		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		\$		53

## XIX. SUPPORT SCHEDULES

[illegible]

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
**(See instructions.)**

[illegible]

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO no If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 60,225  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 5,016
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.



